

<b>Case Number:</b>	CM15-0108888		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	11/14/2002
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York  
 Certification(s)/Specialty: Neurological Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 65 year old male, who sustained an industrial injury on November 14, 2002. He reported an injury to his low back. Treatment to date has included epidural steroid injection, medications, and physical therapy. Currently, the injured worker complains of continued low back pain. The injured worker reports that pain radiates into his bilateral lower extremities and is described as sharp in character. He has associated numbness and tingling of the bilateral lower extremities. He reports that he is unable to sit longer than 45 minutes or stand longer than 15 minutes without increased pain. He rates his pain a 5-7 on a 10-point scale. On physical examination the injured worker is unable to heel and toe walk. He has diminished perception to light touch/pinprick in the left thigh and calf. He reports tenderness to palpation over the mid to lower lumbar spine and has pain with range of motion. He exhibited a positive straight leg raise test on the left side. An MRI of the lumbar spine performed on February 18, 2015 revealed moderate central stenosis at L3-4, mild central canal narrowing at L4-5 and additional spondylitic changes of the lumbar spine. The diagnoses associated with the request include degenerative disc disease at multi-levels with back pain and radiculopathy. The treatment plan includes transforaminal lumbar interbody fusion at L3-L4 with associated three day inpatient hospital stay, assistant surgeon and post-operative lumbar brace.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Transforaminal Lumbar Interbody Fusion L3-L4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The request for transforaminal lumbar interbody fusion L3-L4 is not medically necessary and appropriate.

**Associated surgical service: Length of Stay: Inpatient x 3 days: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Assistant Surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the requested treatment: Transforaminal Lumbar Interbody Fusion L3-L4 is NOT Medically necessary and appropriate, then the requested treatment: Assistant Surgeon is NOT Medically necessary and appropriate.

**Post-operative DME purchase of Aspen LSO Brace: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.